VIEWPOINT

The Need To Serve Rural America

BY SMIRITI SHARMA

According to the Department of Health and Human Services (HHS), there are 6,204 Primary Care Health Professional Shortage Areas (HPSAs) in the United States and 65 million people living in them (HRSA 2010). A report published by the Council on Graduate Medical Education states that although an oversupply of several medical specialties is evident in urban healthcare areas, many rural communities fail to attract a sufficient number of physicians to provide high-quality care to the local populace (COGME 1998). Moreover, studies examining rural healthcare have found that the more specialized a physician is, the less likely he or she is to establish a practice in a rural community; female physicians prefer to settle in an urban area; managed care systems are growing slowly in HPSAs; and enlisted physicians are of little, if any, benefit to the uninsured (Rosenblatt 2000). Rural community residents face increased travel time to reach a medical facility, longer wait times to see a physician, a worse outcome after a traumatic injury or severe illness, and little exposure to preventive medicine (Weldon 2008). A Kaiser Family Foundation report (2007) says that approximately 24,000 physicians will be needed by 2020 to fill the shortage in rural communities.

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The factors that attract physicians to rural areas include a familiarity with a rural community and a desire for the lifestyle and practice style it fosters, including increased autonomy (Ricketts 2007). Assuming there is sufficient economic opportunity, these factors must sufficiently compensate for the advantages of an urban setting, which include a rich cultural and social environment, significant professional support from colleagues, access to emerging technological resources, and higher income (Ricketts 2007).

Some states have incentive packages to entice physicians to rural practice, including loan repayment programs, flexible work options, and visa waivers for foreign practitioners. Two key programs that have been in place for decades — the National Health Service Corps (NHSC) and Conrad State 30 — are being revisited to address the physician shortage in rural America.

NHSC program

The NHSC enlists health professionals for HPSA communities by offering scholarships and loan repayments (NHSC 2010a). Scholarships cover fees, tuition, and a living stipend for practitioners enrolled in an accredited health professional program. Upon graduation, recipients serve as a primary care practitioner in HPSA for 2 to 4 years. Conversely, the NHSC Loan Repayment Program provides to fully trained healthcare professionals $50,000 to repay student loans in exchange for two years of medical service in an HPSA. Upon completion, participants may apply for additional years of support (NHSC 2010a). Since 1972, the NHSC has recruited more than 30,000 clinicians, approximately half of whom have worked in HRSA-supported health centers that provide care to patients regardless of their insurance status and their ability to pay (40 percent of patients seen in these community centers are uninsured) (NHSC 2010a). Moreover, a Mathematica study (NHSC 2010b) found that 52 percent of NHSC physicians were still practicing in some capacity in their assigned HPSA up to 15 years after completion of their commitment. The American Recovery and Reinvestment Act doubled the funding for the NHSC program by adding $300 million to the $135 million appropriation for fiscal year 2009. These additional funds have allowed for another 8,108 clinicians to be recruited to serve 9 million people (Whelan 2009).

Conrad State 30 program

The Conrad State 30 Program, initiated under the Immigration and Nationality Technical Corrections Act of 1994, addresses physician shortages in rural communities by awarding J-1 waivers to international medical graduates (IMG) in each state in exchange for at least 3 years of primary care service in a designated underserved community. In 2002, the 21st Century Department of Justice Appropriations Authorization Act expanded the program, and in 2009 the program was extended until Sept. 30, 2012 (USCIS 2010). The Conrad State 30 Improvement Act recently submitted to Congress for consideration, if passed, would make the program permanent and expand it to include physicians

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who complete their residency and fellowship with an H-1B status in medicine and family practice (OpenCongress 2010). Currently, 3,200 IMGs practice in underserved areas compared with 2,000 U.S. medical graduates practicing in those same areas (J1Waiver.com 2009). One study found that the percentage of IMGs planning to practice in physician shortage areas was 3 times greater than that of U.S. medical graduates (Salsberg 2000). Foreign medical graduates also fill safety net needs at a disproportionately higher rate than that of U.S. medical graduates in areas with low socioeconomic status, high nonwhite populations, and a high infant mortality rate, and in states with a high rural population (Mick 2000).

New programs are needed

Currently, 3,800 physicians, dentists, and other NHSC healthcare providers work in underserved communities across the country, and 4 million people — many of whom do not have health insurance — rely on them for treatment (NHSC 2010c). Approximately 80 percent of NHSC providers continue to provide medical care in a HPSA beyond their initial commitment, 70 percent stay for at least 5 years, and roughly 50 percent stay permanently (NHSC 2010c).

The Conrad State 30 Program has been influential in providing primary care to rural communities by creating a win–win situation in which IMGs are permitted to remain in the United States to provide healthcare to rural communities and also to address the healthcare concerns of new immigrant populations (Mueller 2002). But more such programs are needed

Jefferson Medical College, in Philadelphia, has incorporated the Physician Shortage Area Program (PSAP) into its curriculum. This program recruits and selectively admits students from rural communities who intend to practice in rural and underserved communities.

PSAP students account for 7 percent of each matriculating class (approximately 15 students), and graduates account for 21 percent of the family physicians practicing in rural Pennsylvania that graduated from one of the state's seven medical schools, although they represent only 1 percent of the total Pennsylvania medical school graduates. Retention in the program has remained high, with the number of PSAP graduates currently practicing rural family medicine equal to approximately 87 percent (94 percent for underserved communities) of those practicing 5 to 10 years ago (Rabinowitz 1999).

Programs such as the PSAP represent a viable approach to remediating the physician shortage in rural America and will help bring the medical advances in biopharmaceuticals and medical diagnostics to those areas.

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Disclosure

Smiriti Sharma reports that she has no financial arrangements or affiliations with programs or entities mentioned in this article.